CDC

Table 3. Instructions for Completion of the Exposure to Blood/Body Fluids Form (CDC 57.205)

Information for all blood/body fluid exposures should be recorded using this form. The variables to be entered depend upon whether the facility selects the exposure event only reporting or exposure reporting and management.

♦Demographic data auto-entered by application if part of an existing HCW Demographic Data record (CDC 57.204).

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the application.	Required	Required
Exposure Event #	The exposure event number will be auto-generated by the application.	Required	Required
HCW ID	Enter the HCW's alphanumeric identification number. This identifier is unique to the healthcare facility.	Required	Required
♦HCW Name: Last, First, Middle	Enter the HCW's name.	Optional	Optional
♦Gender	Indicate the gender of the HCW by checking F (Female) or M (Male).	Required	Required
♦Date of Birth	Enter the date of birth of the HCW using the format: mm/dd/yyyy.	Required	Required
♦Work Location	Required. Select the code that best describes the HCW's current permanent work location. This refers to physical work location rather than to department assignment. Location codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.	Required	Required
♦Occupation	Required. Select the occupation code that most appropriately describes the HCW's job. Occupation codes are customized to the facility and set up prior to entering HCW records. See Table 2 for more details.	Required	Required
Clinical Specialty	If Occupation is physician, fellow or intern/resident, enter the appropriate clinical specialty. The list of clinical specialties can be found on Form CDC 57.204.	Conditionally required	Conditionally required
Exposure Type	The default setting is auto-entered by the application as Blood/Body Fluids.	Required	Required
Section I – General Exposure Information			
1. Did the exposure occur at this facility	Choose Y (Yes) or N (No).	Required	Required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
1a. If No, specify the name of facility in which exposure occurred	If the exposure did not occur at the reporting facility, enter the name of the facility where the event occurred.	Conditionally required	Conditionally required
2. Date of exposure	Enter date of exposure in mm/dd/yyyy format.	Required	Required
3. Time of exposure	Enter the time the exposure occurred and whether it was AM or PM.	Required	Required
4. Number of hours on duty	Enter the number of hours the HCW had been on duty when the exposure occurred.	Optional	Optional
5. Is exposed person a temp/agency employee?	Choose Y (Yes) or N (No).	Optional	Optional
6. Location where exposure occurred	Choose the appropriate code for the physical location where the event took place. (This is customized to the facility).	Required	Required
7. Type of Exposure	Check the appropriate exposure type. Check all that apply.	Required	Required
7a. Percutaneous: Did the exposure involve a clean, unused needle or sharp object?	If Type of Exposure was Percutaneous, then check this item.	Conditionally required	Conditionally required
	If percutaneous is checked, then select Yes or No to indicate whether the exposure involved a clean, unused needle or sharp object. If the incident involved a clean, unused needle or sharp object you may not need to report this as an exposure (see your protocol for more information). If not, check No and complete Q8, Q9 and Section II. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
7b. Mucous membrane	If Type of Exposure was Mucous Membrane, then check this item and complete Q8, Q9 and Section III. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
7c. Skin: Was skin intact?	If Type of Exposure was Skin, then check this item.	Conditionally required	Conditionally required
	If Skin is checked, then indicate Y (Yes), N (No) or (U) Unknown for whether the skin remained intact during the exposure. If the answer is No, complete Q8, Q9 and Section III. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
7d. Bite	If Type of Exposure was Bite, then check this item and complete Q9 and Section IV. If following the protocol for exposure management also complete Sections V-XI.	Conditionally required	Conditionally required
8. Type of fluid/tissue involved in exposure	Select the Type of fluid/tissue from the list.	Required	Required
	If Solutions or Body fluids are checked, indicate whether visibly bloody or not visibly bloody. For Body Fluids, indicate the primary body fluid type implicated in the exposure from the list.	Conditionally required	Conditionally required
	If Other is selected for either the Type of Fluid/Tissue involved in the exposure or the Body Fluid Type, please specify the type. (Make sure it is not a body fluid that is already listed in the box on the right side of the form).	Conditionally required	Conditionally required
9. Body site of exposure	Check body site of exposure from the list. Check all sites that were exposed.	Required	Required
	If the Body site of exposure was (Other), please specify the site.	Conditionally required	Conditionally required
Section II – Percutaneous Injury			
1. Was the needle or sharp object visibly contaminated with blood prior to exposure?	Choose Y (Yes) or N (No).	Required	Required
2. Depth of the injury (check one)	Indicate the depth of the injury from the needle or sharp object using the list provided. Exposures that are not obviously superficial (e.g., scratch) or deep (e.g., "muscle contracted" or "touched bone"), should be classified as moderate.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
3. What needle or sharp object caused the injury?	Select one of the following categories: Device, Non-Device Sharp Object, or Unknown Sharp Object. If you select Device in the application you will be provided with a **Device** button that will take you to a screen to enter manufacturer, model, etc. Once a device has been entered you will be able to select it from the drop down list.	Conditionally required	Conditionally required
	If a Non-Device Sharp is selected, please describe the item or object.	Conditionally required	Conditionally required
	Within Devices, there are six categories: *Hollow-bore needles, Suture needles, Other solid sharps, Glass, Plastic, Non-sharp safety devices,* and *Other devices.*		
	If Other known device is selected, please specify.	Conditionally required	Conditionally required
4. Manufacturer and model	Enter the brand name and model of the device used. If the brand and model are unknown, generic device descriptors can be entered.	Conditionally required	Conditionally required
5. Did the needle or other sharp object involved in the injury have a safety feature?	Choose Y (Yes) or N (No). If Yes, answer 5a and 5b. If No, skip to Q6.	Conditionally required	Conditionally required
5a. If Yes, indicate the type of safety feature	If above is Y (Yes), choose one item from the list of safety devices.	Conditionally required	Conditionally required
5b. If the device had a safety feature, when did the injury occur?	Choose the timing of the injury event with relation to the use of the safety device. Check one item from the list provided.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
6. When did the injury occur? (check one) <u>Before use of the item</u>	Choose the timing of the injury event from the list provided. Injuries that occurred prior to intended use and usually involve clean needles or sharp objects. It may also include injuries that occurred with a clean device that passed through bloody gloves.	Conditionally required	Conditionally required
<u>During use of the item</u>	Injuries that occurred during the use of the needle or sharp object. It also includes surgical or other invasive procedures with many steps.		
<u>After use of item, before disposal</u>	Injuries that occurred while in transit to disposal, cleaning instrument or recapping.		
<u>During or after disposal</u>	Injuries that occurred during or after the process of disposal or because of improper disposal of a needle or other sharp object.		
<u>Unknown</u>	Time of injury relative to the use of the device or object is unknown.		
7. For what purpose or activity was the sharp device being used?	Choose from the lists provided. If Other specify the purpose in the space provided. Select Unknown if injury was a result of contact with discarded or uncontrolled sharps, or in circumstances where the intent of device or object use is unknown or cannot be ascertained.	Conditionally required	Conditionally required
8. What was the activity at the time of injury?	Choose the activity being performed at the time of injury involving the sharp object or needle. If the activity being performed at the time of the injury was different than the purpose indicated in Q7, select the activity at the time the actual injury event took place.	Conditionally required	Conditionally required
9. Who was holding the device at the time the injury occurred?	Select one answer.	Conditionally required	Conditionally required
10. What happened when the injury occurred?	Choose one item from the list. If Other, please record details in the space provided.	Conditionally required	Conditionally required
Section III – Mucous Membrane and/or Skin Exposure			
1. Estimate the amount of blood/body fluid exposure	Select the estimated amount of blood or body fluid involved in the mucous membrane or skin exposure. Indicate Unknown if unable to estimate the amount.	Conditionally required	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
2. Activity/event when exposure occurred	Select the activity or event at the time mucous membrane or skin exposure occurred.	Conditionally required	Conditionally required
	If Other is selected record details of the activity or event in the space provided.	Conditionally required	Conditionally required
3. Barriers used by the worker at the time of exposure	Check all that apply.	Conditionally required	Conditionally required
	If Other is selected, list other barriers in the space provided.	Conditionally required	Conditionally required
Section IV – Bite			
1. Wound description	Select the description of the bite wound from the list provided.	Conditionally required	Conditionally required
2. Activity/event when exposure occurred	Choose the activity or event when the bite occurred.	Conditionally required	Conditionally required
	If Other, specify the event in the space provided.	Conditionally required	Conditionally required
Sections V – IX are required when following the protocols for Exposure Management			
Section V – Source Information			
1. Was the source patient known?	Choose Y (Yes) if the source of the exposure (patient) is known. Otherwise, select N (No).	Optional	Required
2. Was HIV status known at time of exposure?	Indicate Y (Yes) if the source patient's serostatus was known at the time of exposure.	Optional	Required
3. Check the test results for the source patient: **Hepatitis B** HbsAg HBeAg Total anti-HBc anti-HBs **Hepatitis C** anti-HCV EIA anti-HCV suppl PCR-HCV RNA **HIV** HIV EIA, ELISA Rapid HIV Confirmatory HIV	Use codes: P= positive, N= negative, I=Indeterminate, U=Unknown, R=Refused and NT=Not tested. Indicate the results of any tests performed prior to the exposure (as found in the medical record) or performed immediately after the exposure. If the source is not known, check U. If the source refuses to be tested, check R. Not all tests listed on the form need to be offered after all exposures.	Optional	Required
Section VI – For HIV Infected Source			
1. Stage of Disease	Indicate the stage of HIV disease of the <u>source</u> patient. Use CDC surveillance definitions. For end stage AIDS and acute HIV illness, use definitions as defined in the protocol.	Optional	Conditionally required

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
2. Is the source patient taking anti-retroviral drugs?	Indicate if the source patient is was taking anti-retroviral drugs at the time of the exposure, Y (Yes), N (No), or U (Unknown).	Optional	Conditionally required
2a. If Yes, indicate drug(s)	If the source patient was taking anti-retroviral drugs at the time of the exposure, list them here. Drug codes are listed in Chapter 7 and will be in a drop down list in the application.	Optional	Conditionally required
3. Most recent CD4 count Date	If available, indicate the most recent CD4 count in mm^3 for the source patient. Enter the month and year of the test for the source patient.	Optional	Conditionally required
4. Viral Load Date	If available, indicate the most recent HIV viral load (# of copies per ml) or Undetectable for the source patient. Enter the month and year of the test.	Optional	Conditionally required
Section VII: Initial Care Given to Healthcare Worker			
1. HIV postexposure prophylaxis Offered?	Choose Y (Yes), N (No), or U (Unknown) if antiretroviral drugs were offered to the HCW following this exposure.	Optional	Required
Taken?	Choose Y (Yes), N (No), or U (Unknown) if antiretroviral drugs were taken by the HCW. If Yes is selected, complete Post-Exposure Prophylaxis/Treatment form (CDC form 57.206).	Optional	Required
2. HBIG given?	Choose Y (Yes), N (No), or U Unknown) for whether Hepatitis B immunoglobulin was given.	Optional	Required
Date administered	Enter date HBIG prophylaxis pertaining to this exposure was administered. Use mm/dd/yyyy format.	Optional	Conditionally Required
3. Hepatitis B vaccine given?	Choose Y (Yes), N (No), or U. (Unknown) for whether Hepatitis B vaccine was given after exposure.	Optional	Required
Date first dose administered	Enter date of first dose of Hepatitis B vaccine (mm/dd/yyyy format). This and subsequent doses to complete the HBV series should be recorded in the HCW's file.	Optional	Conditionally Required

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4. Is the HCW pregnant?	Indicate the pregnancy status of HCW. Choose Y (Yes), N (No), or U (Unknown).	Optional	Conditionally required
4a. If yes, which trimester?	Check 1 (1st trimester), 2 (2nd trimester), or 3 (3rd trimester) at the time of exposure. If stage of pregnancy is unknown, check U.	Optional	Conditionally required
Section VIII – Baseline Lab Testing			
Was baseline testing performed on the HCW?	Choose Y (Yes) or N (No) or U (Unknown). Baseline lab tests should be performed within hours of the exposure .	Optional	Required
HIV EIA HIV confirmatory HepC anti-HCV EIA HepC anti-HCV-supp HepC PCR HCV RNA HepB HBsAg HepB IgM anti-Hbc HepB Total anti-Hbc HepB Anti-HBs	Enter the dates for each test performed and the result (Use codes: P= Positive, N= Negative, I=Indeterminate, U=Unknown, R=Refused).	Optional	Conditionally required
ALT Amylase Blood glucose Hematocrit Hemoglobin Platelets Blood cells in urine WBC Creatinine Other	Additional baseline laboratory tests may be completed to document potential physiologic changes associated with a blood/body fluid exposure. Enter the date (in mm/dd/yyyy format) and result, using the specified units.	Optional	Optional
Section IX – Follow-up			
1. Is it recommended that the HCW return for follow-up of this exposure?	Choose Y (Yes) or N (No).	Optional	Required
1a. If Yes, will follow-up be performed at this facility?	Choose Y (Yes) or N (No).	Optional	Conditionally Required
Section X – Narrative			
In the worker's words, how did the injury occur?	Enter the narrative of the HCW's description of how the injury occurred.	Optional	Optional
Section XI – Prevention			

Data Field	Instructions for Data Collection	Exposure Event Only	Exposure Event and Exposure Management
In the worker's words, what could have prevented the injury?	Enter the narrative of the HCW's assessment of how the injury might have been prevented.	Optional	Optional
Custom Fields	Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. NOTE: Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.	Optional	Optional
Comments	Enter any additional information about the HCW. CDC will not analyze this information.	Optional	Optional